Date Application Received by DHHS: _____

South Carolina Department of Health and Human Services
Application for South Carolina Healthy Connections
Coverage for Children, Pregnant Women, and Families

Note: You only need to tell us the Social Security Number and answer the question about being a US citizen for the people for whom you are applying. However, if you give us your Social Security Number, even if you are not applying for benefits, it may help us process your application faster. We only use Social Security Numbers to help us verify income.

- *Original documents to prove US citizenship and identity must be provided for all persons applying for coverage.*
- *If applying for someone who is not a citizen, United States Citizenship and Immigration Services (USCIS) documents, such as an I-551 (Green Card) or I-94, must be provided to support his/her legal entry in the US.*
- *If applying for Emergency Services Only for someone who is not a citizen, the Emergency Services applicant is not required to provide USCIS documentation or a Social Security Number. Undocumented non-citizens are not required to provide a Social Security Number.*

1. Tell us about yourself (Primary Individual)

Name (First, Middle Initial, Last):	**Social Security Number**: (not required for emergency services)	**Date of Birth**:

Address where you get mail (include apartment number)	**City**	**State**	**Zip Code**	**County**:
Home Address (if not the same as your mailing address)	**City**	**State**	**Zip Code**	**Telephone Number**: ( )

Your Full Name at Birth: This helps us verify citizenship	**County/State where you were born:**	**Your Mother's Full Name at her Birth:**

Sex:	**Marital Status**:	**Check all that apply**	**Are you applying for yourself?**	**Are you currently attending school?**
☐ Female ☐ Male	☐ Single ☐ Widowed ☐ Married ☐ Separated ☐ Divorced	☐ US Citizen ☐ Disabled ☐ Pregnant Due Date: _____	☐ Yes ☐ No **Need retroactive coverage for the past three months** ☐ Yes ☐ No	☐ Yes What grade? ____ ☐ No

Do you have Health Insurance now? ☐ Yes ☐ No If yes, Company Name _____ Policy ID# _____

Are you the parent, stepparent, or guardian of any of the children listed on the application? ☐ Yes ☐ No

What language do you use most?			**Race**			
☐ English	☐ Spanish	☐ Chinese		☐White	☐African American	☐Hispanic
☐ Russian	☐ Sign Language	☐ Vietnamese		☐Cuban	☐Puerto Rican	☐Mexican
☐ Other:				☐Native American/American Indian		☐Asian American
				☐Refugee Entrant	☐Other:	

2. Tell us about your spouse or other adult in the home who may be the parent or guardian of the children

Name (First, Middle Initial, Last):	**Social Security Number**: (not required for emergency services)	**Date of Birth**:

Full Name at Birth: This helps us verify citizenship	**County/State where born:**	**Mother's Full Name at her Birth:**

Sex:	**Marital Status**:	**Check all that apply**	**Applying for coverage?**	**Currently attending school?**
☐ Female ☐ Male	☐ Single ☐ Widowed ☐ Married ☐ Separated ☐ Divorced	☐ US Citizen ☐ Disabled ☐ Pregnant Due Date: _____	☐ Yes ☐ No **Need retroactive coverage for the past three months?** ☐ Yes ☐ No	☐ Yes What grade? ____ ☐ No

Does this person currently have Health Insurance? ☐ Yes ☐ No If yes, Company Name _____ Policy ID# _____

Is this person the parent, stepparent, or guardian of any of the children listed on the application? ☐ Yes ☐ No

Relationship to You?		**Race**				
☐ Spouse	☐ Boyfriend/Girlfriend		☐White	☐African American	☐Hispanic	☐Cuban ☐Puerto Rican
☐ Other:			☐Mexican	☐Native American/American Indian		☐Asian American
			☐Refugee Entrant	☐Other:		

If an Authorized Representative is completing this application, please complete the following:

Name: _____ Phone Number: _____

Address: _____ Relationship: _____

_____

3. Tell us about the children who live with you.

A Social Security Number is not required if applying for Emergency Services Only

	Child 1	Child 2	Child 3
Full Name (First, Middle, Last)			
Social Security Number			
Medicare or Social Security Claim Number			
Date of Birth of Child			
City, County and State where the Child was born			
Sex	☐ Female ☐ Male	☐ Female ☐ Male	☐ Female ☐ Male
Mother's Full Name at her Birth			
Check all that apply to the Child	☐ US Citizen ☐ Disabled ☐ Pregnant Due Date:	☐ US Citizen ☐ Disabled ☐ Pregnant Due Date:	☐ US Citizen ☐ Disabled ☐ Pregnant Due Date:
Race	☐White ☐African American ☐Native American/American Indian ☐Hispanic ☐Cuban ☐Mexican ☐Puerto Rican ☐Asian American ☐Refugee Entrant ☐Other ____	☐White ☐African American ☐Native American/American Indian ☐Hispanic ☐Cuban ☐Mexican ☐Puerto Rican ☐Asian American ☐Refugee Entrant ☐Other ____	☐White ☐African American ☐Native American/American Indian ☐Hispanic ☐Cuban ☐Mexican ☐Puerto Rican ☐Asian American ☐Refugee Entrant ☐Other ____
Is the Child now attending school	☐ Yes School Name and grade ☐ No ____	☐ Yes School Name and grade ☐ No ____	☐ Yes School Name and grade ☐ No ____
Relationship of the Child to the Primary Individual	☐ Child ☐ Step-child ☐ Grandchild ☐ Other ____	☐ Child ☐ Step-child ☐ Grandchild ☐ Other ____	☐ Child ☐ Step-child ☐ Grandchild ☐ Other ____
Relationship of the Child to the Spouse/Other Adult in the Home	☐ Child ☐ Step-child ☐ Grandchild ☐ Other ____	☐ Child ☐ Step-child ☐ Grandchild ☐ Other ____	☐ Child ☐ Step-child ☐ Grandchild ☐ Other ____
Does the Child get Child Support payments?	☐ Yes ☐ No If yes, Court Ordered?☐ Yes ☐ No Amount: ____ Paid by: ____	☐ Yes ☐ No If yes, Court Ordered?☐ Yes ☐ No Amount: ____ Paid by: ____	☐ Yes ☐ No If yes, Court Ordered?☐ Yes ☐ No Amount: ____ Paid by: ____
Do you pay someone for childcare for this Child while you work or attend school?	Name of Provider or Daycare Center ____ ____ Phone Number: ____ Amount you pay: ____ How often: ____ ABC Voucher? ☐ Yes ☐ No	Name of Provider or Daycare Center ____ ____ Phone Number: ____ Amount you pay: ____ How often: ____ ABC Voucher? ☐ Yes ☐ No	Name of Provider or Daycare Center ____ ____ Phone Number: ____ Amount you pay: ____ How often: ____ ABC Voucher? ☐ Yes ☐ No
Need retroactive coverage for the past three months?	☐ Yes ☐ No Months:____	☐ Yes ☐ No Months:____	☐ Yes ☐ No Months:____
Does Child have Health Insurance now?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	If yes, please give us a copy of the front and back of all health insurance cards.		
If the Child does not have health insurance now, did the Child have Health Insurance in the past six (6) months? *(Not including Medicaid)*	☐ Yes ☐ No If **Yes**, please answer the following: Type of Policy ____ Company Name ____ Policy ID# ____ Date Policy Ended: ____ Reason Insurance ended: ____ ____ ____ ____	☐ Yes ☐ No If **Yes**, please answer the following: Type of Policy ____ Company Name ____ Policy ID# ____ Date Policy Ended: ____ Reason Insurance ended: ____ ____ ____ ____	☐ Yes ☐ No If **Yes**, please answer the following: Type of Policy ____ Company Name ____ Policy ID# ____ Date Policy Ended: ____ Reason Insurance ended: ____ ____ ____ ____

	Child 4	Child 5	Child 6
Full Name (First, Middle, Last)			
Social Security Number			
Medicare or Social Security Claim Number			
Date of Birth of Child			
City, County and State where the Child was born			
Sex	☐ Female ☐ Male	☐ Female ☐ Male	☐ Female ☐ Male
Mother's Full Name at her Birth			
Check all that apply to the Child	☐ US Citizen ☐ Disabled ☐ Pregnant Due Date:	☐ US Citizen ☐ Disabled ☐ Pregnant Due Date:	☐ US Citizen ☐ Disabled ☐ Pregnant Due Date:
Race	☐White ☐African American ☐Native American/American Indian ☐Hispanic ☐Cuban ☐Mexican ☐Puerto Rican ☐Asian American ☐Refugee Entrant ☐Other ____________	☐White ☐African American ☐Native American/American Indian ☐Hispanic ☐Cuban ☐Mexican ☐Puerto Rican ☐Asian American ☐Refugee Entrant ☐Other ____________	☐White ☐African American ☐Native American/American Indian ☐Hispanic ☐Cuban ☐Mexican ☐Puerto Rican ☐Asian American ☐Refugee Entrant ☐Other ____________
Is the Child now attending school	☐ Yes School Name and grade ☐ No ____________	☐ Yes School Name and grade ☐ No ____________	☐ Yes School Name and grade ☐ No ____________
Relationship of the Child to the Primary Individual	☐ Child ☐ Step-child ☐ Grandchild ☐ Other ____________	☐ Child ☐ Step-child ☐ Grandchild ☐ Other ____________	☐ Child ☐ Step-child ☐ Grandchild ☐ Other ____________
Relationship of the Child to the Spouse/Other Adult in the Home	☐ Child ☐ Step-child ☐ Grandchild ☐ Other ____________	☐ Child ☐ Step-child ☐ Grandchild ☐ Other ____________	☐ Child ☐ Step-child ☐ Grandchild ☐ Other ____________
Does the Child get Child Support payments?	☐ Yes ☐ No If yes, Court Ordered?☐ Yes ☐ No Amount: ____________ Paid by: ____________	☐ Yes ☐ No If yes, Court Ordered?☐ Yes ☐ No Amount: ____________ Paid by: ____________	☐ Yes ☐ No If yes, Court Ordered?☐ Yes ☐ No Amount: ____________ Paid by: ____________
Do you pay someone for childcare for this Child while you work or attend school?	Name of Provider or Daycare Center ____________ ____________ Phone Number: ________ Amount you pay: ________ How often: ________ ABC Voucher? ☐ Yes ☐ No	Name of Provider or Daycare Center ____________ ____________ Phone Number: ________ Amount you pay: ________ How often: ________ ABC Voucher? ☐ Yes ☐ No	Name of Provider or Daycare Center ____________ ____________ Phone Number: ________ Amount you pay: ________ How often: ________ ABC Voucher? ☐ Yes ☐ No
Need retroactive coverage for the past three months?	☐ Yes ☐ No Months:____________	☐ Yes ☐ No Months:____________	☐ Yes ☐ No Months:____________
Does Child have Health Insurance now?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	If yes, please give us a copy of the front and back of all health insurance cards.		
If the Child does not have health insurance now, did the Child have Health Insurance in the past six (6) months? *(Not including Medicaid)*	☐ Yes ☐ No If **Yes**, please answer the following: Type of Policy ________ Company Name ________ Policy ID# ________ Date Policy Ended: ________ Reason Insurance ended: ______ ____________ ____________ ____________	☐ Yes ☐ No If **Yes**, please answer the following: Type of Policy ________ Company Name ________ Policy ID# ________ Date Policy Ended: ________ Reason Insurance ended: ______ ____________ ____________ ____________	☐ Yes ☐ No If **Yes**, please answer the following: Type of Policy ________ Company Name ________ Policy ID# ________ Date Policy Ended: ________ Reason Insurance ended: ______ ____________ ____________ ____________

4. Tell us about the income of each family member in the home.
Enter GROSS pay before taxes and deductions, not take home pay. Enter zero ("0") if you are not working. **You must send us proof of income for the past 4 weeks**.

Your Income from Employment	**Spouse/Other Adult's Income from Employment** *(if living in the home)*
Name of person working _____	Name of person working _____
Employer's Name _____	Employer's Name _____
Employer's Address _____	Employer's Address _____
Does this person work for the Government of the State of South Carolina? ☐ Yes ☐ No	Does this person work for the Government of the State of South Carolina? ☐ Yes ☐ No
Employer's Phone Number (including area code) _____	Employer's Phone Number (including area code) _____
Gross amount earned per pay period before taxes? $_____	Gross amount earned per pay period before taxes? $_____
How often paid? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly	How often paid? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly

Is anyone self-employed? ☐ Yes ☐ No If yes, please name Self-Employment Business and/or Partnership _____

You must send copies of all the most recently filed Personal and Business Federal income tax forms including all schedules.

Does anyone in your home receive, or have applied for, any other income? ☐ Yes ☐ No
If Yes, check all boxes that apply and complete the table below

☐ Social Security benefits (RSDI) ☐ Supplemental Security Income (SSI) ☐ Disability benefits
☐ Pension/retirement benefits ☐ Workers' compensation ☐ Unemployment benefits
☐ Veterans benefits ☐ Money from friends or relatives ☐ Rental Income
☐ Military allotments ☐ Room and/or board income ☐ Interest/dividend income
☐ Land contract, mortgage or other notes payable to a household member (Please provide a copy of the contract, mortgage, note or other agreement)
☐ Other: _____

Person receiving/expecting money	Income source/type	How often received	Amount received	Expected to continue?	Date expecting, if not yet started
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

5. If your family does not have any income, explain how you pay your bills. _____

6. Does the equity value of all your assets add up to more than $30,000? Do not count the value of the home you live in or up to $20,000 of equity value per vehicle for each licensed driver.

☐ **Yes, my assets are over $30,000** ☐ **No, my assets are less than $30,000**

Assets are things that you own, such as cars, boats, trailers, non-homestead property, checking and savings accounts, cash, and CDs. Equity value is how much something is worth minus any money owed on it. (For example, a vehicle that is valued at $5000, and $2000 is still owed on it, has an equity value of $3000.)

7. Do you pay court ordered child support for a child outside your home? *(If yes, please provide proof)* ☐ Yes ☐ No

Name of Child	How much do you pay?	How often do you pay this amount?

8. Do you pay someone to take care of a dependent adult while you work or attend school? ☐ Yes ☐ No

Name of Adult	Who do you pay?	How much do you pay?	How often do you pay?

IMPORTANT

Check below to tell us what you attached.

- **Sending this information in with the application will help us to process your application faster.**
- **You must read and sign this form on the last page to complete your application.**
  - ☐ Proof of Income
    - ☐ Copies of pay stubs for the **last 4 weeks for any adult person listed**; *or* a letter from employer that shows last 4 weeks of GROSS pay.
    - ☐ A copy of the letter telling the gross amount of any benefits received (Social Security, Unemployment, VA, Workers' Compensation, etc.)
    - ☐ Proof of all other income for the last 4 weeks, including child support.
      NOTE: You may be required to apply for additional potential benefits, such as unemployment or Social Security Benefits.
  - ☐ Proof of income for the past 3 months if you have received medical services.
  - ☐ If you are self employed, the most recent income tax forms including all schedules.
  - ☐ Verification of the childcare/dependent adult expenses (statement from daycare, receipt, etc.)
  - ☐ United States Citizenship and Immigration Services (USCIS) documents, such as an I-551 (Green Card) or I-94, for each non-citizen applying for full Healthy Connections. Does not apply to Emergency Services Only.
  - ☐ Original Documents of citizenship and identity for each US citizen applying for coverage. (If you have provided this information since July 1, 2006, you do not have to provide it again.)

Other documents can be used to provide proof. If you are not sure what to send, call our toll-free line at 1-888-549-0820 for help.

The South Carolina Department of Social Services' Child Support Enforcement Division (CSED) provides services to establish paternity and child support, modify child support orders, and enforce support orders. Services are available to Healthy Connections beneficiaries without charge. I understand that if I check "no" and ask for child support services later, I will have to pay a $25 fee. I want to voluntarily apply for these services:
☐ Yes ☐ No

Rights and Responsibilities

1. I know that my children under age 19 who are eligible for Medicaid can have free health checkups under a special prevention program called Early and Periodic Screening, Diagnosis and Treatment (EPSDT).

2. I know that the information I have given is confidential. I understand that, except as specified below, information including medical information can be released only for purposes directly related to the administration of the Healthy Connections Program. At times, the Department of Health and Human Services (DHHS) will release information to organizations that they hire to carry out specific purposes, but those organizations will have agreed to be bound by the same guidelines for release of information. Furthermore, I know that personal health information I provide or that is later gathered by DHHS is covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and I will be receiving a Notice of Privacy Practices along with my Healthy Connections Card(s).

   a. I know that, in accordance with the federal rules governing the Healthy Connections Program, any information I have given must be reviewed and verified by DHHS staff. Also, I understand that I must cooperate fully with state and federal workers if my case is reviewed. No additional permission by me is needed to get verification or other information.

   b. I know that, in accordance with the federal rules governing the Healthy Connections Program, DHHS staff must provide information about my family and me to a computer system called the State Income and Eligibility Verification System (IEVS). This computer system allows DHHS to compare the information about my family and me with information from other agencies, and allows other state (including agencies from other states) and federal agencies to use information gathered on this application to verify eligibility and determine benefit amounts for their programs. Other agencies include, but are not limited to, the Internal Revenue Service, Social Security Administration, and Employment Security Commission, other states' Medical Assistance programs, and the TANF and Food Stamp agency (Department of Social Services (DSS), in this state). Immigration status will be verified with the Department of Homeland Security (DHS).

c. I know that, unless I specify otherwise, information about my family and me may be shared by DHHS for the purpose of making a proper referral of my case to other sources of services or treatment, in accordance with federal and state law. When possible, I, or my responsible party, will be asked to agree. However, I further understand that in the case of mandatory reporting, DHHS must report, and cannot honor my specification to the contrary.

d. I know that, unless I specifically ask not to be included, information about services (including medical services) provided to my family and me will be stored in a data warehouse operated by the South Carolina Budget and Control Board, Office of Research and Statistics, and that other state agencies that provide services to me or my family will be allowed to access that information in order to be sure that services provided to my family and me are sufficient and necessary.

3. I know that my Social Security Number, which I am required to provide, under §1137(a) (1) of the Social Security Act [42 U.S.C. 1320b-7(a) (1)], may be used or released in connection with the exceptions in Item 2, above.

4. I know that according to Federal law and US Department of Health and Human Services (HHS) policy, DHHS cannot discriminate on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, I should contact HHS by writing to The HHS Director, Office of Civil Rights, Room 506F, 200 Independence Avenue, SW, Washington, DC 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). HHS is an equal opportunity provider and employer.

5. I know that the Healthy Connections Program does not pay medical expenses that a third party, such as a private health insurance company or someone who injures me, is supposed to pay. I therefore assign and give my rights to any payments from a liable third party to the DHHS up to the payment amount that Healthy Connections has made for my medical care. This assignment applies to any of my minor children who may be injured. These payments may include payments from hospital and health insurance policies or payments received as a settlement from an accident.

6. Completion of a Medical Support Referral Form is required on an absent parent(s) if the custodial parent/caregiver relatives want Healthy Connections coverage.

7. I must report any and all changes in my income, deductions, resources, living arrangements, members of the household, or other information that will affect medical help within ten (10) days of the date of the change(s). I understand that if I fail to notify the department promptly, I may lose benefits and be subjected to penalties or prosecution.

   If eligibility is for my child(ren) only, I am not required to report any changes in my situation, except for change of address. If I report any other changes in my situation, it will not affect their eligibility for benefits until the next scheduled review.

8. I know that I may request a hearing if I believe an error has been made in processing my application.

☐ **I have read the Rights and Responsibilities, or they have been read to me.**
(If possible, both the Applicant and Authorized Representative should sign.)

Applicant's Signature: _____ Date: _____

Signature of Authorized Representative: _____ Date: _____